INDIVIDUAL SUPPORT AGREEMENT

Vermont Developmental Disabilities Services

May 2010

ISA Guidelines Page No.

NAME: _____

DESIGNATED AGENCY: _____

PROVIDER: _____

PROVIDER: _____

CHECK IF: SELF-MANAGING ❒ OR FAMILY-MANAGING ❒

INDIVIDUAL SUPPORT AGREEMENT TERM:

BEGIN DATE: _____ **END DATE:** _____

PERSON(S) RESPONSIBLE FOR MEETING YOUR HEALTH NEEDS:

❒ **AGENCY/SERVICE COORDINATOR** ❒ **FAMILY/GUARDIAN** ❒ **SELF**

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1. WHAT ARE YOUR LONG TERM GOALS AND DREAMS? (WHERE DO YOU WANT TO LIVE? IDEAL JOB? WHO DO YOU WANT TO LIVE WITH? DREAM VACATION? WHAT DO YOU WANT TO LEARN?)

_____
_____
_____
_____
_____

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2. WHAT DO YOU EXPECT TO BE DIFFERENT AS A RESULT OF RECEIVING SUPPORTS? WHAT OUTCOMES DO YOU EXPECT TO MEET WITH THE HELP OF YOUR SUPPORTS? THESE OUTCOMES MUST BE CLEARLY STATED AND MEASURABLE.

_____
_____
_____
_____
_____

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3. What are the Areas of Support you are funded to receive? How much support and what is the cost of the support that you are funded to receive? What is your Authorized Funding Limit?

Waiver ☐ Medicaid Fee-for-Service (TCM, Clinic, Rehab, PASRR) ☐ ICF/MR ☐

Funded Area	Amount of Support	Cost (yearly)
Service Planning and Coordination	Hours/Week	
Community Supports	Hours/Week	
	Describe	
Employment Services	Hours/Week	
	Describe	
Respite – Individual	Hours/Week Days/Year	
Clinical Interventions	Hours/Week	
	Describe:	
Crisis – Individual	Hours/Week Days/Year	
Housing and Home Support	Hours/Week Days/Year	
	Describe	
Transportation	Miles/Week Van (annual cost)	
Administration Costs		
Total Authorized Funding Limit		**$**

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4. What do service coordinators, workers, and others need to do to help you reach your outcomes? Describe what support people do to support you for each outcome, i.e. when, where, and how they support you.

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5. What kind of information should be gathered, and how often should information be collected on each of your outcomes to tell if you are making progress? Who is responsible for collecting the information?

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6. How often will the QDDP review the progress for each outcome?

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7. List additional supports, services, accommodations, adaptive equipment, and resources your provider(s) will coordinate or provide.

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8. How much of your day and night can you be left alone? Under what circumstances?

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9. Describe other specific restrictions that you have? For example, are your activities or your rights restricted in any way? You and your guardian (if you have one) must give approval for this to happen (unless it is court ordered) and they must be included as a part of this ISA.

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10. What do others need to know about the way you communicate to better understand and support you? How would you like others to communicate with you?

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11. Check off the documents below that apply to this ISA:

- ☐ **Behavior support plan**
- ☐ **Special Care Procedures Plan**
- ☐ **Communication Plan**
- ☐ **Work Plan**
- ☐ **Other** _____

INDIVIDUAL SUPPORT AGREEMENT

REQUIRED APPROVALS FORM

WE HAVE REVIEWED THE INDIVIDUAL SUPPORT AGREEMENT WITH ALL CURRENT SUPPORTING DOCUMENTS AND INDICATE OUR APPROVAL BELOW:

INDIVIDUAL **DATE**

GUARDIAN (IF YOU HAVE ONE) **DATE**

SERVICE COORDINATOR (IF OTHER THAN QDDP) **DATE**

QDDP **DATE**

AGENCY PROVIDING SERVICES **DATE**
(ONLY IF QDDP IS NOT EMPLOYED BY AGENCY)

PHYSICIAN **DATE**
(REQUIRED ONLY FOR CLINIC, REHABILITATION, TRANSPORTATION & ICF/DD)

INDIVIDUAL SUPPORT AGREEMENT REVIEW/CHANGE FORM

NAME: _____ **DATE:** _____

QDDP COMPLETING THIS FORM: _____

ISA BEGIN DATE: _____ **ANNUAL REVIEW DATE:** _____

WHAT IS THE STATUS OF EACH OF THE INDIVIDUAL'S OUTCOMES?

_____
_____
_____
_____

WHAT ARE THE INDIVIDUAL'S COMMENTS ABOUT HIS OR HER SATISFACTION WITH SUPPORTS?

_____
_____
_____

WHAT IS THE GUARDIAN'S (IF THE INDIVIDUAL HAS ONE) LEVEL OF SATISFACTION?

_____
_____
_____

WHAT ARE THE FAMILY'S COMMENTS (IF APPLICABLE)?

_____
_____
_____

WHAT ARE THE PROVIDER'S COMMENTS? (IF ISA CHANGES, COMPLETE AN ISA CHANGE FORM.)

_____
_____
_____

☐ **CHECK HERE IF A CHANGE IS MADE IN THE ISA AND PROVIDE THE INFORMATION ON THE BACK**

EFFECTIVE DATE OF CHANGE:

1. WHAT IS THE NEW OUTCOME?

2. WHAT ARE THE SUPPORTS YOU EXPECT FROM SUPPORT PEOPLE? DESCRIBE WHAT SUPPORT PEOPLE DO TO SUPPORT YOU, WHEN AND WHERE THEY SUPPORT YOU, AND HOW THEY NEED TO SUPPORT YOU.

3. WHAT DO SERVICE COORDINATORS, WORKERS, AND OTHERS NEED TO DO TO HELP YOU REACH YOUR OUTCOMES? DESCRIBE WHAT SUPPORT PEOPLE DO TO SUPPORT YOU FOR EACH OUTCOME, I.E. WHEN, WHERE, AND HOW THEY SUPPORT YOU.

4. HOW OFTEN WILL THE OUTCOME BE REVIEWED?

5. INDICATIONS OF APPROVAL FOR REVIEW AND/OR CHANGES:

INDIVIDUAL **DATE**

AGENCY PROVIDING SERVICES **DATE**

GUARDIAN (IF THE INDIVIDUAL HAS ONE) **DATE**

PHYSICIAN **DATE**
(REQUIRED ONLY FOR CLINIC, REHABILITATION, TRANSPORTATION & ICF/DD)

QDDP **DATE**